ASPiH conference abstracts for IJoHS supplement 2021

PERSPECTIVES

163   **GO BIG OR GO HOME: THE USE OF LARGE-SCALE SIMULATION**

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What? In 2019, we carried out our first experimental large-scale simulation exercise with great success. The initial findings of the study were presented at ASPiH 2019. This is an update on our journey using large-scale inter-professional simulation (IPE). From our initial simulation, we identified the following key themes: (1) students' educational expectations; (2) their experience of multi-disciplinary working; (3) the theory to practice gap and (4) gaining experience in a safe environment. From this, we realized that our students needed more of this type of simulation activity and that the hands-off facilitation style that we used helped with learning and preparation for practice. Students responded positively to having to put their leadership skills into practice, learning in a safe environment in a real-time situation, something that, despite great placements, they often felt unable to do in the 'real world'. This real-time simulation-enhanced innovative thinking and emphasized human factor principles. This type of learning experience promoted learning and working together across the multi-disciplinary field with both qualified and pre-registration students. The impact of working with 'qualified' professionals added to the realism of the simulation. We found that the debrief was key in the development of real-time simulation as it was enhanced by good-quality debriefing.

So what? Following the initial large-scale simulation, we planned and delivered two more events before COVID-19 prevented us from continuing. Both were large-scale events, but we made adaptations each time to enhance the students' learning experience. What we have managed to achieve over the lockdown period is to plan and prepare for further events and, in hindsight, this has better prepared us. So, what have we done in this period of enforced distancing? We have gone through a period of change management to align all our curriculum to being simulation-based, and have developed and implemented a framework for the integration of skills and simulation. We have sent (nearly) all our lecturing staff from across our courses, nursing, operating department practitioner, midwifery, paramedic, trainee nursing associate and social work on a simulation train the trainer course to understand the pedagogy and discipline that is the backbone of simulation. This has been a great success and has generated a lot of inter-professional conversations and development of simulation. We have designed and developed a large-scale simulation that can be run in a COVID compliant way.

12   **REMOTE CONTROL: THE VIRTUAL PARTICIPANT DURING SIMULATION**

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What? At the onset of the COVID-19 pandemic, learner operating department practitioners (ODPs) were withdrawn from their clinical placements, thus removing their learning opportunities. This greatly affected their confidence and key knowledge. Staffordshire University adopted a blended learning approach to education for their Health and Social Care learners. This approach allowed the learners to attend campus for simulation sessions in small groups adhering to COVID-19 guidelines of the University. This approach had some limitations; it identified a disparity in provision for those learners who were unable to attend in person due to isolating, shielding or home-schooling provisions. In response to this, we created a system using available technology to allow learners to actively participate in the simulation virtually. The virtual learners were included within the pre-brief, orientation to the equipment and surroundings, simulated sessions and post-simulation de-brief. The virtual learners were given objectives throughout the simulated session to ensure inclusivity and unity of direction, and were then included within the de-brief, which is arguably the most impactful phase of the simulation [1]; they were invited to share their findings so that they became an integral part of the conversation. This was achieved using Microsoft Teams, high-definition remote cameras including Scotia Medical Observation and Training System (SMOTS) and Bluetooth interface for sound control. The room was organized to offer a balanced view for both attendees and virtual learners. Additionally, adaptations were made to the delivery method to integrate both types of learners within the simulation.

So what? This project successfully allowed virtual learners who ordinarily would have missed the learning opportunity altogether to participate. Early feedback from the virtual learners proved this adaption successful; virtual learners reported feeling motivated and connected to the class. This approach could be adapted for future simulation sessions to ensure inclusivity for learners who are unable to attend campus.

REFERENCE

1. Ciceron F, Besch G, Benkhadra M, et al. Individual versus collective debriefing after interprofessional training course simulation: The randomised DEBRIEF-SIM trial. Anaesth Crit Care Pain Med. 2021;40(2):100828. https://doi-org.ezproxy.staffs.ac.uk/10.1016/j.accpm.2021.100828.

193   **BALANCING EDUCATION AND PRACTICE: A REFLECTION FROM A SIMULATION EDUCATOR DURING THE COVID-19 PANDEMIC**

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What? I consider myself privileged to divide my work time between my roles as a clinical simulation educator and as an intensive care nurse in a large teaching hospital. I find that working alternate weeks in educational and clinical roles can be challenging because both demand complementary but different skills. However, I am thrilled to have the opportunity to continue caring for patients alongside supporting and learning with colleagues. Balancing these roles during a pandemic presented me with new challenges and rewards, and reflection on these experiences has given me some fascinating insights. As the COVID-19 pandemic progressed and the number of patients requiring admission to the Critical Care Unit increased, the

units were expanded and staff were redeployed from other areas to provide support. These 'surge' staff required rapidly developed simulation-based training to allow them to work in this unfamiliar environment within a restricted scope of practice. Being involved with delivering this training as well as working with surge staff in Critical Care afforded me a deeper understanding of the surge role and the unique challenges it presented. Once surge training was completed and I returned to delivering our standard simulation-based education courses, my experiences of working clinically continued to enrich my teaching because I felt somewhat familiar with some of the challenges our learners were facing as the pandemic continued.

So what? Over the last year, I have felt conflicted at times; when working clinically during the peak of the pandemic, there was very little time to facilitate learning at the bedside, and during my educator weeks I relished the opportunity to support and teach but felt guilty for spending time away from colleagues and patients in Critical Care Unit. However, continuing with both roles better equipped me to answer questions and to provide support during surge training, particularly for those staff who had not yet spent time on the units. When assisting with other courses as a faculty member, I was able to deeply empathize with participants who encountered situations that I had become familiar with in practice – for example, communicating with others when wearing full personal protective equipment – which helped me to validate and normalize some of the experiences shared during debrief discussions. Through continuing to reflect on my time spent working in these environments during the pandemic so far, I hope to present my learning and recommendations for optimizing practice under challenging circumstances.

| 186 | **REFLECTIONS ON REMOTE SIMULATION: WHAT DOES THIS MEAN THAT CANDIDATES MISS?** |

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What? Our organization has been running some courses remotely since autumn 2020. Sessions for medical students and foundation doctors have taken place, allowing those who are isolating or shielding to participate, and facilitating the training of those who are outside our organization. We are now writing many courses with remote learning in mind and creating our course materials in digital format. This means that we are not starting from scratch if changes in circumstance prevent face-to-face training in the future. The remote format involves candidates controlling an 'avatar' in-centre, supported by a confederate (in nursing or junior doctor role), with access to a digital notes bundle. The screen on Microsoft Teams has a relatively fixed room view taking up the majority of the screen, with a change in feed to a different camera if appropriate to the flow of the scenario – to focus on the defibrillator, for example, with observations in a corner, and results popping up when requested. There is no option for candidates to alter this view. During a dry-run of a scenario involving a simulated patient (played by a faculty member) with hallucinations due to delirium, the candidate struggled in their appreciation of how abnormal the patient's behaviours were, as they were unable to see all the small

movements that were evident to those of us in the room, and low volume speech and muttering might have been difficult to hear, despite the faculty member wearing a microphone, though may have been easier through headphones. We sought feedback on the format and the feasibility for the scenario from the candidate, and the phrase 'I didn't see/hear that' was used a lot.

So what? This has led me to wonder how much detail our candidates are dialling in from home, particularly those who are using a tablet, phone or laptop with a small screen, and have been missing, and how that might have affected their behaviour and clinical reasoning. Submitted feedback makes little reference to missing things in the course of the scenarios, but some candidates seem to have had more issues than others. This may have been due to technical or connectivity problems but could be viewed as a limitation of the set-up in its current format. Reviewing the feedback, while some expressed frustration about technical issues, there are many more comments about how they had enjoyed the experience and hoped it will continue. The jury seems to be out, but there is much to work on as we move forward.

| 205 | **SIMULATION AS A FORM OF IMMERSIVE THEATRE** |

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What? Immersive theatre is a style of theatre that removes the fourth wall of traditional theatre turning the audience into participants and engaging the five senses such as sight, sound, touch, taste and smell; a concept applied equally to multi-professional, human factor-based simulation. Peter Brook, one of our greatest theatre directors, says, 'Drama is exposure; it is confrontation; it is a contradiction, and it leads to analysis, construction, recognition and eventually to an awakening of understanding'. This is without doubt what we do in simulation. We create scenarios, 'the drama', we create managing deteriorating patients, the 'confrontation and contradiction' and we enter debriefing, the 'analysis, construction and eventual awakening of understanding'. Using the concepts of immersive theatre and drama, creating more realistic environments and authentic interactions, we can offer the participants a greater sense of reality in which to practice vital inter-professional medical care. High-fidelity simulation encompasses more than just a technological top of the range manikin which often comes at a premium cost. High-fidelity simulation is an attack on all of the senses, visually sick patients, noises and smells of the environment, even touch and taste. The soundscape of an emergency room, smells of humans, drugs, equipment, tastes of stewed tea and warm water, the touch of a sick patient or a disruptive relative in a visually authentic space creates the perfect setting for an immersive simulation experience.

So what? By implementing psychological, sociological and physical fidelity, we offer a unique way of practicing essential skills of interprofessional working not only to enhance patient care and safety but also to allow a greater understanding of ourselves and others in stressful, urgent and critical situations. Applying ideas from the world of drama and theatre, creating authentic immersive environments can